		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036798

Facility Name: Rosewood Care Center of Joliet

Address: 3401 Hennepin Drive (Number) Joliet (City) 60435 (Zip Code)

County: Will

Telephone Number: (815) 436-5900 **Fax #** ( )

IDPA ID Number: 431478199001

Date of Initial License for Current Owners: 01/31/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: : Cindy A. Tefteller **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2000 to 06/30/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, L.L.C. 233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			13,364	13,364	8
9	SNF/PED					9
10	ICF	2,820	21,588		24,408	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,820	21,588	13,364	37,772	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.24%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/31/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/31/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 13,364

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2001 Fiscal Year: 06/30/2001

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 **Report Period Beginning:** 07/01/2000 **Ending:** 06/30/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	188,923	21,387	11,663	221,973		221,973		221,973			1
2	Food Purchase		160,186		160,186		160,186	(5,029)	155,157			2
3	Housekeeping	111,448	22,267		133,715		133,715		133,715			3
4	Laundry	40,656	13,501		54,157		54,157		54,157			4
5	Heat and Other Utilities			104,883	104,883		104,883	231	105,114			5
6	Maintenance	12,584	8,137	69,171	89,892		89,892	21,083	110,975			6
7	Other (specify):* Sanitation			23,713	23,713		23,713		23,713			7
8	**TOTAL General Services**	353,611	225,478	209,430	788,519		788,519	16,285	804,804			8
	B. Health Care and Programs											
9	Medical Director			10,987	10,987		10,987		10,987			9
10	Nursing and Medical Records	2,019,510	203,347	600	2,223,457		2,223,457		2,223,457			10
10a	Therapy	58,975	12,095	770,670	841,740		841,740	(4,695)	837,045			10a
11	Activities	59,221	5,125	690	65,036		65,036		65,036			11
12	Social Services	37,244	30	2,400	39,674		39,674		39,674			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,174,950	220,597	785,347	3,180,894		3,180,894	(4,695)	3,176,199			16
	C. General Administration											
17	Administrative			1,180,801	1,180,801		1,180,801	(1,037,733)	143,068			17
18	Directors Fees											18
19	Professional Services			10,669	10,669		10,669	41,527	52,196			19
20	Dues, Fees, Subscriptions & Promotions			30,633	30,633		30,633	(10,671)	19,962			20
21	Clerical & General Office Expenses	144,349	30,544	20,610	195,503		195,503	165,989	361,492			21
22	Employee Benefits & Payroll Taxes			349,969	349,969		349,969	33,665	383,634			22
23	Inservice Training & Education											23
24	Travel and Seminar			793	793		793	(64)	729			24
25	Other Admin. Staff Transportation			4,786	4,786		4,786	17,383	22,169			25
26	Insurance-Prop.Liab.Malpractice			34,766	34,766		34,766	5,191	39,957			26
27	Other (specify):*											27
28	**TOTAL General Administration**	144,349	30,544	1,633,027	1,807,920		1,807,920	(784,713)	1,023,207			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,672,910	476,619	2,627,804	5,777,333		5,777,333	(773,123)	5,004,210			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rosewood Care Center of Joliet #0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			11,259	11,259		11,259	224,846	236,105			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,403	26,403		26,403	590,558	616,961			32
33	Real Estate Taxes			85,297	85,297		85,297		85,297			33
34	Rent-Facility & Grounds			1,529,334	1,529,334		1,529,334	(1,515,323)	14,011			34
35	Rent-Equipment & Vehicles			11,887	11,887		11,887		11,887			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,664,180	1,664,180		1,664,180	(699,919)	964,261			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		279,612	21,298	300,910		300,910		300,910			39
40	Barber and Beauty Shops			18,788	18,788		18,788		18,788			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		279,612	105,786	385,398		385,398		385,398			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,672,910	756,231	4,397,770	7,826,911		7,826,911	(1,473,042)	6,353,869			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,576)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,780)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(23,521)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(453)	2		13
14	Non-Care Related Interest	(26,403)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment	(64)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,336)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,160)	20		28
29	Other-Attach Schedule Marketing Salary	(53,303)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (122,596)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,350,446)	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,350,446)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,473,042)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Rosewood Care Center of Joliet

ID# 0036798

Report Period Beginning: 07/01/2000

Ending: 06/30/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (53,303)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(53,303)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center of Joliet **#** 0036798 **Report Period Beginning:** 07/01/2000 **Ending:** 06/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,029)	0	0	0	0	0	0	0	0	0	0	(5,029)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	231	0	0	0	0	0	0	0	0	231	5
6	Maintenance	0	0	21,083	0	0	0	0	0	0	0	0	21,083	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,029)	0	21,314	0	0	0	0	0	0	0	0	16,285	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(4,695)	0	0	0	0	0	0	0	0	0	(4,695)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(4,695)	0	0	0	0	0	0	0	0	0	(4,695)	16
	C. General Administration													
17	Administrative	0	(1,160,801)	123,068	0	0	0	0	0	0	0	0	(1,037,733)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,542	39,985	0	0	0	0	0	0	0	0	41,527	19
20	Fees, Subscriptions & Promotions	(11,496)	0	825	0	0	0	0	0	0	0	0	(10,671)	20
21	Clerical & General Office Expenses	(56,083)	677	221,395	0	0	0	0	0	0	0	0	165,989	21
22	Employee Benefits & Payroll Taxes	0	290	33,375	0	0	0	0	0	0	0	0	33,665	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(64)	0	0	0	0	0	0	0	0	0	0	(64)	24
25	Other Admin. Staff Transportation	0	0	17,383	0	0	0	0	0	0	0	0	17,383	25
26	Insurance-Prop.Liab.Malpractice	0	0	5,191	0	0	0	0	0	0	0	0	5,191	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(67,643)	(1,158,292)	441,222	0	0	0	0	0	0	0	0	(784,713)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(72,672)	(1,162,987)	462,536	0	0	0	0	0	0	0	0	(773,123)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Rosewood Care Center of Joliet** **#** **0036798** **Report Period Beginning:** **07/01/2000** **Ending:** **06/30/2001**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	198,309	26,537	0	0	0	0	0	0	0	0	224,846	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(49,924)	640,482	0	0	0	0	0	0	0	0	0	590,558	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,529,334)	14,011	0	0	0	0	0	0	0	0	(1,515,323)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(49,924)	(690,543)	40,548	0	0	0	0	0	0	0	0	(699,919)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(122,596)	(1,853,530)	503,084	0	0	0	0	0	0	0	0	(1,473,042)	45

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fee	$ 1,180,801	HSM Management Services, Inc.	100.00%	$	$ (1,180,801)	1
2	V								2
3	V	10a	Therapy	770,670	Rosewood Therapy Services, Inc.	0.00%	765,975	(4,695)	3
4	V								4
5	V	34	Rent	1,529,334	Joliet Real Estate, Inc.	0.00%		(1,529,334)	5
6	V	30	Depreciation		Joliet Real Estate, Inc.		198,309	198,309	6
7	V	32	Interest		Joliet Real Estate, Inc.		623,994	623,994	7
8	V	32	Amortization - Loan Fee		Joliet Real Estate, Inc.		16,488	16,488	8
9	V	19	Professional Fees		Joliet Real Estate, Inc.		1,542	1,542	9
10	V	21	Office Expense		Joliet Real Estate, Inc.		677	677	10
11	V	17	Owners' Compensation		Joliet Real Estate, Inc.		20,000	20,000	11
12	V	22	Payroll Taxes		Joliet Real Estate, Inc.		290	290	12
13	V								13
14	Total			$ 3,480,805			$ 1,627,275	$ * (1,853,530)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	See Schedule VIII	$	HSM Management Services, Inc.	100.00%	$ 123,068	$ 123,068	15
16	V	21	See Schedule VIII		HSM Management Services, Inc.	100.00%	221,395	221,395	16
17	V	22	See Schedule VIII		HSM Management Services, Inc.	100.00%	33,375	33,375	17
18	V	25	See Schedule VIII		HSM Management Services, Inc.	100.00%	17,383	17,383	18
19	V	30	See Schedule VIII		HSM Management Services, Inc.	100.00%	26,537	26,537	19
20	V	34	See Schedule VIII		HSM Management Services, Inc.	100.00%	14,011	14,011	20
21	V	19	See Schedule VIII		HSM Management Services, Inc.	100.00%	39,985	39,985	21
22	V	26	See Schedule VIII		HSM Management Services, Inc.	100.00%	5,191	5,191	22
23	V	6	See Schedule VIII		HSM Management Services, Inc.	100.00%	21,083	21,083	23
24	V	5	See Schedule VIII		HSM Management Services, Inc.	100.00%	231	231	24
25	V	20	See Schedule VIII		HSM Management Services, Inc.	100.00%	825	825	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 503,084	$ * 503,084	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Larry Vander Maten	President	Management	75.00%	715,279	4	7.01%	Salary	$ 62,214	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	215,093	4	7.01%	Salary	17,404	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 79,618		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 6/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HSM Management Services, Inc.
Street Address: 11701 Borman Drive, Suite 315
City / State / Zip Code: St. Louis, MO 63146
Phone Number: (314) 994-9070
Fax Number: (314) 994-9912

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries-Officers	Total Cost	75,137,033	17	$ 849,990	$ 849,990	5,270,093	$ 59,618	1
2	21	Salaries-Others	Total Cost	75,137,033	17	2,658,369	2,658,369	5,270,093	186,457	2
3	22	Payroll Taxes	Total Cost	75,137,033	17	282,151		5,270,093	19,790	3
4	22	Employee Benefits	Total Cost	75,137,033	17	140,469		5,270,093	9,852	4
5	25	Travel	Total Cost	75,137,033	17	180,072		5,270,093	12,630	5
6	30	Depreciation	Total Cost	75,137,033	17	351,550		5,270,093	24,658	6
7	34	Building Rent	Total Cost	75,137,033	17	199,753		5,270,093	14,011	7
8	19	Professional Services	Total Cost	75,137,033	17	570,072		5,270,093	39,985	8
9	21	Telephone	Total Cost	75,137,033	17	200,687		5,270,093	14,076	9
10	26	Insurance	Total Cost	75,137,033	17	74,012		5,270,093	5,191	10
11	21	Taxes & Licenses	Total Cost	75,137,033	17	11,527		5,270,093	809	11
12	21	Office Supplies	Total Cost	75,137,033	17	285,895		5,270,093	20,053	12
13	6	Maintenance	Total Cost	75,137,033	17	300,583		5,270,093	21,083	13
14	5	Heat & Other Utilities	Total Cost	75,137,033	17	3,293		5,270,093	231	14
15	20	Dues & Subscriptions	Total Cost	75,137,033	17	11,759		5,270,093	825	15
16	17	Direct - Admin	Direct Cost	1	1	63,450	63,450	1	63,450	16
17	17	Direct - Admin	Direct Cost	16	16	851,444	851,444	0	0	17
18	22	Direct - Payroll Taxes	Direct Cost	1	1	3,733		1	3,733	18
19	22	Direct - Payroll Taxes	Direct Cost	16	16	51,685		0	0	19
20	30	Direct - Depreciation	Direct Cost	1	1	1,879		1	1,879	20
21	30	Direct - Depreciation	Direct Cost	16	16	25,809		0	0	21
22	25	Direct - Travel	Direct Cost	1	1	4,753		1	4,753	22
23	25	Direct - Travel	Direct Cost	16	16	134,449		0	0	23
24										24
25	TOTALS					$ 7,257,384	$ 4,423,253		$ 503,084	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America		X	Mortgage	Varies	03/99	$ 9,789,265	$ 9,064,755	03/2006	PRM+1/2	$ 641,871	1
2	Less: Related Party Interest Income										(17,877)	2
3	Amortization of Loan Fees										16,488	3
4	Interest Income										(23,521)	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 9,789,265	$ 9,064,755			$ 616,961	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,789,265	$ 9,064,755			$ 616,961	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 **Report Period Beginning:** 07/01/2000 **Ending:** 06/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 86,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 84,897	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,303)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 86,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 85,297	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	91,326	8
	1997	86,644	9
	1998	84,379	10
	1999	84,056	11
	2000	85,739	12

1999 Payment $42,028

2000 Payment $42,869

Accrual = Remaining 2000 (42,869) + 1/2 of estimated 2001 tax bill (43,731)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center of Joliet COUNTY Will

FACILITY IDPH LICENSE NUMBER 0036798

CONTACT PERSON REGARDING THIS REPORT Lou Netemeyer

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-03-26-203-001-0000		$ 85,738.60	$ 85,738.60
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 85,738.60	$ 85,738.60

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,200 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	39,200	1990	$ 230,225	1
2					2
3	TOTALS	39,200		$ 230,225	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1990	$ 3,475,917	$	25	$ 139,037	$ 139,037	$ 1,529,407	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	General Requirements			1991	25,516		25	1,021	1,021	10,721	9
10	Developer Fee			1991	28,980		25	1,159	1,159	12,170	10
11	Construction Period Interest			1991	20,364		25	815	815	8,558	11
12	Arch and Eng Fees			1991	4,459		25	178	178	1,869	12
13	Storm Sewer			1991	32,675		25	1,307	1,307	13,724	13
14	Lawn Sprinkler			1991	10,990		25	440	440	4,620	14
15	Landscaping			1991	55,127		25	2,205	2,205	23,153	15
16	Mass Grading			1991	54,747		25	2,190	2,190	22,995	16
17	Asphalt Paving			1991	48,390		25	1,936	1,936	20,328	17
18	Sanitary Sewer			1991	8,069		25	323	323	3,392	18
19	Water Line			1991	15,500		25	620	620	6,510	19
20	Driveway and Sidewalks			1991	55,932		25	2,237	2,237	23,489	20
21	Walk-In Cooler Refrigerator			1991	6,888		20	344	344	3,612	21
22	Sink			1991	2,049		10	101	101	2,049	22
23	Exhaust and Air Hood			1991	4,670		10	233	233	4,670	23
24	Fire Exting. System			1991	1,647		10	79	79	1,647	24
25	Combo. Range/Hood			1991	3,925		10	191	191	3,925	25
26	Building Signage			1991	7,300		10-15	434	434	5,926	26
27	Generator/Accessories			1991	15,764		20	788	788	8,274	27
28	Cubicle Curtain Track			1991	6,176		10	305	305	6,176	28
29	6 Stainless Doors			1991	2,685		10	129	129	2,685	29
30	Monument Sign			1991	3,193		10	162	162	3,193	30
31	Wallcovering			1991	19,849		10	991	991	19,849	31
32	Carpeting			1991	9,585		10	474	474	9,585	32
33	Nurse Call System			1991	28,217		20	1,411	1,411	14,816	33
34	Fire Alarm System			1991	15,724		20	786	786	8,253	34
35	Continued on Next Page										35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Door Bell	1991	$ 1,026	$	20	$ 51	$ 51	$ 536	37
38	Door Alarm	1991	5,773		20	289	289	3,035	38
39	Public Address	1991	5,022		20	251	251	2,636	39
40	Cable	1991	15,712		20	786	786	8,253	40
41	Hot Water Boiler	1991	6,792		10	341	341	6,792	41
42	Hot Water Heater	1991	7,841		10	393	393	7,841	42
43	Load Bank Generator	1997	3,945		10	395	395	1,712	43
44									44
45	Leasehold Improvements - Facility:								45
46	Painting/Baseboards/Tiling	1995	14,902	2,128	7	2,128		13,712	46
47	Carpeting	1996	4,157	594	7	594		3,245	47
48	Floor Drain	1997	1,604	229	7	229		840	48
49	Entry Floor Mat	1999	1,213	173	7	173		404	49
50	Ceiling Tiles	1999	1,820	260	7	260		585	50
51	Plants	1999	2,441	349	7	349		756	51
52	Wallpaper/Wallpaper Install/Blinds	1999	14,251	2,036	7	2,036		4,718	52
53	Air System	1999	13,860	1,980	7	1,980		4,125	53
54	Carpeting	1999	14,300	2,043	7	2,043		3,575	54
55	Computer Cabling	2000	2,392	200	7	200		200	55
56									56
57									57
58	Leasehold Improvements - Manaagement Company:								58
59	Office Construction/Improvements	1995	537		5			537	59
60	Office Design	1995	49		5			49	60
61	Office Shelving	1996	115		4			115	61
62	Office Expansion	1996	507		4			507	62
63	Office Expansion	1997	1,356		3			1,356	63
64	Office Expansion	1998	766		3	255	255	709	64
65	Office Addition	1999	378		3	126	126	252	65
66	Door Locks	1999	189		3	63	63	100	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,085,286	$ 9,992		$ 172,838	$ 162,846	$ 1,842,186	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 689,879	$ 1,267	$ 48,483	$ 47,216	5-7 Yrs	$ 578,682	71
72	Current Year Purchases	43,276		3,953	3,953	5-7 Yrs	3,953	72
73	Fully Depreciated Assets	48,106					48,106	73
74								74
75	TOTALS	$ 781,261	$ 1,267	$ 52,436	$ 51,169		$ 630,741	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	$ 42,400	$	$ 10,831	$ 10,831	4 Yrs	$ 25,400	76
77										77
78										78
79										79
80	TOTALS			$ 42,400	$	$ 10,831	$ 10,831		$ 25,400	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,139,172	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 11,259	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 236,105	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 224,846	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,498,327	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

N/A - ONLY HIRE CERTIFIED AIDES
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-8	hrs	$	55,912	$ 274,547	$	55,912	$ 274,547	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		5,805	50,782		5,805	50,782	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		67,036	440,646	12,095	67,036	452,741	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				249,005		249,005	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Ambulance, X-Ray, Enterals Other (specify): & Lab Supplies	39-8				21,298	30,607		51,905	13
14	TOTAL			$	128,753	$ 787,273	$ 291,707	128,753	$ 1,078,980	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 **Report Period Beginning:** 07/01/2000 **Ending:** 06/30/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 274,938	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (71,000))	1,491,870		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,526		6
7	Other Prepaid Expenses	1,991		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Def Inc Tax Benefit	24,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,806,325	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	79,810		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(34,694)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 45,116	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,851,441	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 477,139	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	219,571		29
30	Accrued Salaries Payable	222,276		30
31	Accrued Taxes Payable (excluding real estate taxes)	70,623		31
32	Accrued Real Estate Taxes(Sch.IX-B)	86,600		32
33	Accrued Interest Payable	10,696		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	720,026		36
37	Accrued Rent	13,257		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,820,188	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,820,188	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 31,253	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,851,441	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 21,199	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 21,199	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	221,454	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(211,400)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 10,054	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 31,253	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,408,340	1
2	Discounts and Allowances for all Levels	(3,524,200)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,884,140	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,247,995	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,247,995	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	23,012	13
14	Non-Patient Meals	4,576	14
15	Telephone, Television and Radio	2,780	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 30,368	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	23,521	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 23,521	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Other Income	341	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 341	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,186,365	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	788,519	31
32	Health Care	3,180,894	32
33	General Administration	1,807,920	33
	B. Capital Expense		
34	Ownership	1,664,180	34
	C. Ancillary Expense		
35	Special Cost Centers	319,698	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,826,911	40
41	**Income before Income Taxes (line 30 minus line 40)****	359,454	41
42	**Income Taxes**	(138,000)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 221,454	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,921	2,016	$ 59,189	$ 29.36	1
2	Assistant Director of Nursing	1,581	1,659	36,280	21.87	2
3	Registered Nurses	29,886	31,360	646,856	20.63	3
4	Licensed Practical Nurses	22,737	23,858	400,102	16.77	4
5	Nurse Aides & Orderlies	74,039	77,690	785,189	10.11	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,424	4,643	58,975	12.70	8
9	Activity Director					9
10	Activity Assistants	5,999	6,295	59,221	9.41	10
11	Social Service Workers	3,479	3,651	37,244	10.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,902	22,982	188,923	8.22	15
16	Dishwashers					16
17	Maintenance Workers	1,207	1,266	12,584	9.94	17
18	Housekeepers	14,447	15,160	111,448	7.35	18
19	Laundry	5,486	5,756	40,656	7.06	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,525	14,191	144,349	10.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,543	6,866	91,894	13.38	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	207,176	217,393	$ 2,672,910 *	$ 12.30	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	530	$ 11,663	1-3	35
36	Medical Director	Contract	10,987	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	690	11-3	44
45	Social Service Consultant	135	2,400	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	705	$ 25,740		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	30	600	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	30	$ 600		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
W. Matjasich	Administrator	0.00%	$ 63,450
Total Direct Administrator Cost from HSM Mgmt - Line 17, col 7			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,450

B. Administrative - Other

Description	Amount
Management Fee	$ 1,180,801
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,180,801
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accountant/Consultant	$ 10,669
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 10,669

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 94,672
Unemployment Compensation Insurance	29,556
FICA Taxes	201,736
Employee Health Insurance	18,403
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Management Company Allocations	33,665
Employee Relations	2,756
Employee Uniforms	2,846
TOTAL (agree to Schedule V, line 22, col.8)	$ 383,634

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,853
Health Care Worker Background Check	
(Indicate # of checks performed 109)	1,528
Management Company Allocations	825
Misc. Dues/Subscriptions	6,756
Promotional Advertising	8,496
Less: Public Relations Expense	(674)
Non-allowable advertising	(3,662)
Yellow page advertising	(4,160)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,962

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	729
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 729

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Schedule Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet **#** 0036798 **Report Period Beginning:** 07/01/2000 **Ending:** 06/30/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **65,882** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **4,576**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **No facility specific audit report**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.